Dóchas

The Irish Association of
Non Governmental
Development Organisations

# Mainstreaming **HIV/AIDS** in Humanitarian Action

## AN INTRODUCTION

A Dóchas Resource

# CONTENTS





## Acknowledgements


Sincere thanks to the Dóchas member agencies working in the HIV/AIDS and humanitarian sectors who collaborated in shaping the document. Special thanks are also due to colleagues in the UK who provided comments on the draft text: Ann Smith at Cafod; Mary Yetter at Oxfam GB and Rachel Baggaley at Christian Aid.


***Note:***
*Where useful resource references are available on the internet, their website addresses have been cited. However, this does not guarantee that these publications will continue to be located at those sites referenced.*

# Abbreviations

| | |
|---|---|
| **ACORD** | Agency for Co-operation and Research in Development |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ARV** | Anti-retroviral |
| **CTC** | Community-Based Therapeutic Care |
| **FAO** | Food and Agriculture Organisation of the United Nations |
| **HBC** | Home Based Care |
| **HIV** | Human Immunodeficiency Virus |
| **IASC** | Inter-Agency Standing Committee |
| **ICRISAT** | International Crops Research Institute for the Semi-Arid Tropics |
| **IDU** | Injection Drug User |
| **IFRC** | International Federation of Red Cross and Red Crescent Societies |
| **IPPF** | International Planned Parenthood Federation |
| **MCH** | Mother and Child Health Centre |
| **MTCT** | Mother to Child Transmission |
| **NFI** | Non-Food Items |
| **NGO** | Non Governmental Organisation |
| **PEP** | Post Exposure Prophylaxis |
| **PLWHA** | People Living with HIV/AIDS |
| **RENEWAL** | Regional Network on HIV/AIDS, Rural Livelihoods and Food Security |
| **SODIS** | Solar Water Disinfection |
| **SFP** | Supplementary Feeding Programme |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **TFP** | Therapeutic Feeding Programme |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNHCR** | United Nations High Commission for Refugees |
| **UNICEF** | United Nations Children's Fund |
| **UNFPA** | United Nations Population Fund |
| **VCT** | Voluntary Counselling and Testing |
| **WFP** | World Food Programme of the United Nations |
| **WHO** | World Health Organisation of the United Nations |

# Executive **Summary**

The compilation of this resource was initiated by the Dóchas HIV/AIDS Working Group in collaboration with humanitarian practitioners in Ireland. Its compilation is viewed by both the HIV/AIDS and humanitarian sectors in Ireland as an activity representing the beginning of a longer-term process of learning and collaboration on mainstreaming HIV/AIDS in humanitarian programming. The purpose of this resource is to:

- Provide HIV/AIDS and humanitarian practitioners with an introduction to the meaning of mainstreaming HIV/AIDS within the context of humanitarian programming.
- Provide practitioners with introductory ideas for discussion and action that are emerging in the existing literature in relation to mainstreaming HIV/AIDS in humanitarian programmes, from preparedness to response and recovery 'phases'.

The resource should therefore function as an introductory and 'stepping stone' text that assists practitioners to begin considering the basic issues around mainstreaming HIV/AIDS in their work, and to feel more confident in negotiating key discussion documents and guidelines. These key texts, which have informed the content of the resource, represent an important basis for learning more about mainstreaming HIV/AIDS in humanitarian programming.[1]



Compiling an introductory resource such as this bears a number of limitations that should also be made explicit. The existing literature on mainstreaming HIV/AIDS in humanitarian action is at present fragmentary. This resource is not therefore a comprehensive introduction to mainstreaming HIV/AIDS in emergencies in all sectors or phases of response. Rather it synthesises some of the key ideas for action in the currently existing literature. This means that ideas for mainstreaming HIV/AIDS in some areas outweigh ideas available in relation to other areas of programming. In addition, the majority of lessons that have been drawn on in the current literature have been extracted from the recent experience of food insecurity in Southern Africa (2002/03) to the detriment of potential learning from other geographical regions. To counteract these imbalances practitioners are directed to further specific guidelines, articles or organisations in order to continue learning.

Part of the reason for the fragmentary nature of the current literature is because it is so recent and generally has not been informed by thorough community based evaluations. Rather the current literature represents a range of ideas to be tested and evaluated in practice. This means that the ideas for action presented here should be approached pragmatically, weighed up based on context and adjusted through a 'trial and error' and 'learning by doing' approach. There are no linear paths to mainstreaming HIV/AIDS, and HIV/AIDS affects individuals, families, communities and states in multilayered and heterogeneous ways, this demands an approach that is flexible and responsive to diverse realities and contexts.

The key messages reflected in this resource include:

- Mainstreaming HIV/AIDS internally in humanitarian organisations should take place hand in hand with mainstreaming HIV/AIDS in humanitarian environments. This is because in order for agencies to develop a serious institutional commitment to mainstreaming HIV/AIDS programmatically, staff members must simultaneously and continuously be supported in coping with the impact of HIV/AIDS in their lives.

[1] The current key texts on mainstreaming HIV/AIDS in humanitarian programming are outlined in the concluding section of the booklet. This resource should also be read with wider humanitarian guidelines in mind, specifically SPHERE Project Handbook, *Humanitarian Charter and Minimum Standards in Disaster Response*, Revised Edition, 2004; *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief*, 1994; and *People in Aid, Code of Best Practice in the Management and Support of Aid Personnel*, ODI, 1998.

- Unequal power relationships are central to understanding how HIV is transmitted and how HIV/AIDS impacts on people's lives. Gender relationships in particular impact enormously on how people are affected by HIV/AIDS. Out of the huge numbers of people infected with HIV/AIDS the majority are women and girls due to women's higher physical susceptibility to infection and women's weakened position in controlling how and with whom they have sex. Women and girls also tend to be affected most severely in terms of bearing the costs of caring for those who are sick through adjusting their lives in order to cope with the economic and social burdens of HIV/AIDS. Addressing unequal power relationships means that humanitarian actors must examine unequal relationships within their own organisations and adopt more equitable, community-led and critical responses that prioritise analysis of power, over 'top-down' donor-driven approaches. This perspective places the protection of vulnerable groups and people living with and affected by HIV/AIDS among disaster affected communities at the centre of planning and implementation by prioritising their voices and interests.
- There is need for consideration of both short and long-range perspectives in mainstreaming HIV/AIDS. Response to disaster situations requires that the immediate vulnerabilities of people living with and affected by HIV/AIDS are addressed and further transmission of HIV infection minimised. In addition longer-term support that may be required should also be considered due to the slower rate of recovery after an emergency due to the continued impacts of HIV/AIDS.



Some of the potential implications for learning that can be drawn from this include: firstly, the need for Irish humanitarian agencies to embark on, or continue with, already ongoing processes of internal mainstreaming throughout their organisations. Secondly, the onus is on humanitarian organisations to test emerging ideas for mainstreaming HIV/AIDS in their programming in the various phases of response. This means adjustment of work plans in order to allow for engagement with the key guidelines and adapting, and expanding on the existing suggestions which they propose. Thirdly, mechanisms for sharing and documenting learning in a collaborative way should be strengthened. For this to be achieved, concerted and long-term efforts must be made by practitioners at personal, agency and inter-agency levels, within programme contexts, and across diverse sectors. Despite some progress, there unfortunately remains a pervasive level of silence surrounding the issue of HIV/AIDS in humanitarian programmes. This highlights a need for a far more self critical and responsive approach by practitioners in this field. The initiation of this resource by the Irish HIV/AIDS and humanitarian sectors demonstrates a welcome commitment to breaking this silence and placing the fight against the monumental human suffering that is a consequence of HIV/AIDS at the centre of the humanitarian agenda.

*Nessa Ní Chasaide*

**Independent Consultant**

April 2005

# PART I



# Mainstreaming HIV/AIDS

# CHAPTER ONE

# Links Between HIV/AIDS and Humanitarian Action

## Key Issues

- The multi-layered social, economic and psychological suffering caused by HIV/AIDS is of long-term humanitarian concern. Of particular concern is how HIV/AIDS impacts most severely on vulnerable groups, such as women and girls.
- People living with and affected by HIV/AIDS in humanitarian contexts are particularly vulnerable to the impacts of disaster. Humanitarian agencies must specifically consider how people living with and affected by HIV/AIDS are being affected by disasters and modify their programmes in order to address these specific vulnerabilities which are both short and long term.
- Humanitarian situations can directly increase the risk of spread of HIV infection among disaster affected populations through blood and sexual routes of transmission. This can be due to reduced capacities within the state to protect people from HIV infection and the adoption of damaging behaviour by individuals living in disaster contexts. Humanitarian agencies must take steps to ensure that potential for HIV transmission is minimised in their programmes by strengthening health systems and tackling damaging behaviour in emergencies by recognising that abuses of power and increased powerlessness are key factors in increasing people's susceptibility to HIV infection.
- This modification of work is termed 'mainstreaming HIV/AIDS'. Mainstreaming HIV/AIDS means modifying the core work of agencies in light of HIV/AIDS - institutionally, in programmes and in policy areas.
- Lessons learned so far in mainstreaming HIV/AIDS in humanitarian action include a) that mainstreaming HIV/AIDS in organisations and in programmes should happen simultaneously; b) questions of power and powerlessness must be a central aspect of HIV/AIDS mainstreaming analysis and c) short and long range perspectives should be considered in mainstreaming HIV/AIDS processes.



## 1. Connections between HIV/AIDS, gender and humanitarian crisis

HIV/AIDS must be of concern to humanitarian practitioners for a number of interrelated reasons. The enormous suffering that is a consequence of HIV/AIDS is a humanitarian concern in itself. Mortality from HIV/AIDS each year exceeds mortality from conflicts world-wide. UNAIDS estimated that by 2001 approximately 60 million people had contracted HIV and an estimated 20 million had died. In 2001 alone, an estimated 5 million people are believed to have been infected with HIV and there were an estimated 3 million AIDS deaths in the same year. As many as 90% of people infected with HIV are unaware that they have the virus. The social, economic and psychological suffering caused by HIV/AIDS not only impacts severely on the people infected, but also acutely impacts on the families, friends and communities who care for people living with the virus, for example through increased medical costs, loss of incomes and the emergence of child-headed households. HIV/AIDS is also causing long term, negative impacts on societies at state levels by weakening the capacities of state services to function due to the enormous loss of skilled labour force.

HIV/AIDS has particularly acute impacts on economically vulnerable people who tend to be more susceptible to HIV infection and to the negative impacts of the disease on their quality of life. This is because HIV/AIDS rapidly depletes the resources of vulnerable households. The gendered impact of HIV/AIDS is also particularly acute. Out of the huge numbers of people infected, the majority are women and girls due to women's higher physical susceptibility to infection and women's weakened position in controlling how and with whom they have sex. Women and girls also tend to be affected most severely in terms of bearing the costs of caring for those who are sick through adjusting their lives in order to cope with the economic and social burdens of HIV/AIDS. Minimising the spread and impacts of HIV/AIDS is therefore intimately linked to addressing the inequalities of gendered power relations that limit women's sexual choices and power to control their lives.

Such causes and consequences of HIV/AIDS are well documented within development literature. What is less well acknowledged is the impact of HIV/AIDS in humanitarian situations. The link between HIV/AIDS and humanitarian situations can be viewed as twofold:

*Firstly*, people already living with, and affected by HIV/AIDS in humanitarian contexts are particularly vulnerable to the impacts of disaster. This is because the ongoing impacts of HIV/AIDS - such as the stress on families, communities and state coping mechanisms, along with the gendered impact of this - are already being felt. The severe disruption and dislocation caused by humanitarian situations greatly exacerbates these existing vulnerabilities by further weakening the resilience of those infected and affected, to cope with the effects of the disaster and in turn with the ongoing impacts of HIV/AIDS in their lives. There is also a much longer-term implication to this which is that people and communities affected by HIV/AIDS can experience far greater difficulties in recovering from a disaster due to the continuing impacts of the disease.



**Humanitarian agencies must therefore specifically consider how people living with, and affected by, HIV/AIDS are being affected by disasters and modify their programmes in order to address these specific vulnerabilities which are both short and long term. If the effects of HIV/AIDS are *not* taken into account, humanitarian programmes are in danger of ignoring and even increasing the difficulties experienced by people coping with the impact of HIV/AIDS in their lives both in the short and long term.**

*Secondly,* humanitarian situations can directly increase the risk of spread of HIV infection among disaster affected populations. Rates of HIV infection can increase through blood and sexual routes of transmission due to reduced capacities within the state to protect people from HIV infection and through the adoption of damaging behaviour by individuals living in conflict and disaster contexts. Rates of HIV infection can increase through blood transmission routes in disaster situations, as weakened infrastructure during emergencies can create difficulties in screening blood or blood products in addition to the potential of increased unsafe intravenous drug use during emergencies. Spread of HIV infection through unsafe sexual behaviour can also potentially increase during disasters due to shifts toward more damaging sexual behaviour such as women being forced to turn to sex work due to loss of livelihood; potentially higher rates of unsafe sexual practices among the affected population; and increased potential of sexual abuse of vulnerable people, especially of women, by armed groups and humanitarian actors.

**Humanitarian agencies must therefore take steps to ensure that potential for HIV transmission is minimised in their programmes. This means that sectors such as health must be strengthened in emergencies to ensure that HIV infection is not inadvertently transmitted through transfusions of unscreened blood or from mother to child due to lack of transmission from mother to child prevention programmes. In addition agencies must tackle the issue of damaging behaviour in emergencies by recognising that abuses of power and increased powerlessness are key factors in increasing people's susceptibility to HIV infection. Critically, agencies must recognise that humanitarian groups exercise a high level of power in emergency situations. Therefore how humanitarian programmes are designed and how humanitarian staff respond can either reinforce or undermine the vulnerabilities of disaster-affected populations and thus impact on people's risk of becoming infected with HIV and the course of the HIV/AIDS epidemic.**

## 2. What does 'mainstreaming' mean in theory and practice?

The need for humanitarian agencies to respond to HIV and AIDS in their work does not mean that agencies must divert their core work toward HIV/AIDS specific programmes. Rather, agencies must ensure that their core work is modified in light of HIV and AIDS. **Dóchas defines mainstreaming HIV/AIDS as *a process of analysis and response to the HIV/AIDS crisis throughout an organisation. Mainstreaming addresses HIV/AIDS at all levels of policy and programme and in the workplace.*** This definition implies three key components to mainstreaming HIV/AIDS - in organisations (institutionally), in programmes and in policy work. This resource focuses on the former two aspects.

**Mainstreaming HIV/AIDS in organisations** is in order to reduce an organisations vulnerability to HIV infection and the impacts of AIDS. This involves direct 'AIDS work' with staff, such as the provision of HIV prevention education and treatment and the modification of the way in which an organisation works, such as resourcing organisations to address chronic illness within the workforce.

**Mainstreaming HIV/AIDS in programmes** refers to the modification of development and humanitarian programmes to take into account the disaster affected populations' increased vulnerability to HIV infection and the negative impacts of HIV/AIDS.



Some practitioners describe mainstreaming HIV/AIDS in organisations and in programmes as adopting a HIV/AIDS 'lens'.[2] Across the existing literature there is some consensus on what initial steps should be taken in adopting the 'HIV/AIDS lens' in humanitarian action. These lessons include that:

- Mainstreaming HIV/AIDS in organisations should go hand in hand with mainstreaming HIV/AIDS externally in programme environments.
- Questions of power and powerlessness should be at the centre of mainstreaming initiatives, especially in terms of adopting community-lead approaches with high participation of HIV affected people and vulnerable groups in disaster affected communities; adopting principles and good practice with regard to protection and gender equality; and utilising effective co-ordination methods among humanitarian actors as an advocacy approach to mainstreaming HIV/AIDS programmatically.
- Mainstreaming HIV/AIDS should have a short and long-range perspective, from emergency preparedness to response phases to recovery 'phases' and beyond.

The following chapters of this booklet provide an introduction to these areas.

**Useful Resources**

- Harvey, Paul, *HIV/AIDS and Humanitarian Action,* HPG Research Report, April 2004, http://www.odi.org.uk/hpg/publications_reports.html.
- Smith, Ann, *HIV/AIDS and Emergencies: Analysis and recommendations for practice,* ODI Network HPN Paper, February 2002.
- Holden, Sue, *AIDS on the Agenda; Mainstreaming HIV/AIDS in Development and Humanitarian Programmes,* ActionAid, Oxfam GB, Save the Children UK, 2003, http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm
- Holden, Sue, *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes,* ActionAid, Oxfam GB, Save the Children UK, 2004

[2] Loevinsohn & Gillespie, describe the HIV/AIDS lens in *HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding, Discussion Paper No 157,* International Food Policy Research Institute, http://www.ifpri.org/themes/hiv/hivpubs.asp.

# PART II



# Mainstreaming HIV/AIDS in Organisations and Programmes

# CHAPTER TWO

# Cross-Cutting Consideration: Power and Powerlessness



## Key Issues

- Humanitarian agencies should strive to ensure that damaging power relationships are confronted and challenged both institutionally and in humanitarian programme contexts.
- Damaging power relationships, especially damaging gender relationships can be challenged through training of staff on HIV/AIDS and gender; inclusion of HIV positive people and female staff in recruitment; building more equitable space for discussion between organisations and communities; and placing the interests and voices of vulnerable groups at the centre of programme planning.
- Safety and dignity of vulnerable groups should be a central concern across all sectors in particular with regard to physical and sexual exploitation. Accountability on incidences of sexual exploitation should be enforced and provision of efficient psychological and medical care for survivors of physical or sexual assault.
- Co-ordination between agencies should be promoted in order to build greater commitment to and accountability in mainstreaming HIV/AIDS and to link agencies mainstreaming initiatives to mainstreaming strategies of other authorities.

## Power and Powerlessness

The question of power is central to how vulnerable individuals are to HIV infection and to the negative impacts of HIV/AIDS affecting their lives. Humanitarian agencies should strive to ensure that damaging power relationships are confronted and challenged both internally within their own organisations and externally in their programme contexts.

***Challenging Unequal Power Relationships, especially consider Gender Related Power Relationships***

- Damaging power relationships can be challenged through training staff on HIV/AIDS and gender; prioritising employment policies inclusive of HIV positive people and female staff; routinely and collectively considering the power relations at work between staff members with each other and between staff members and the communities. Adopting more community-centred approaches can foster involvement of disaster-affected people.
- Reduction of stigma directed toward PLWHA and stigma associated with the issue of HIV/AIDS can be achieved through HIV/AIDS awareness and by involving staff and community members in analysing the problem and in developing responses.
- Agencies should ensure that women's right to represent the interests of communities affected by emergencies is promoted. Skilled women staff should be employed in particular on issues of health, legal, political or financial entitlements. Activities such as assessments and interviews should include women staff who have skills (gender and HIV/AIDS analysis; language) and understanding to carry out the exercise. Ensuring that women have access to safe women-only spaces, co-ordinated by women, is also an important way of providing space for women to voice concerns.

### *Protection of Vulnerable Groups*

- Protection of the most vulnerable groups, in particular against physical and sexual violence and manipulation should be a central consideration. Groups who may be particularly vulnerable to exploitation include women and widows; boys and girls - especially orphaned, heads of households; unaccompanied children; elderly people; chronically sick and disabled people. Security from sexual violence should be provided in emergency contexts and accountability from any staff involved in relief operations who commit sexual violence or coercion, through use of codes of conduct and effective reporting mechanisms, enforced. Speedy and supportive psychological and medical support must be provided for those traumatised by physical or sexual violence.
- Ensuring women have autonomy in voicing their issues by involving women in decision-making, on programme designs and implementation is also a critical aspect of protection initiatives. This helps build more equal control over how resources are managed and distributed so that exploitation of women is minimised.
- Making HIV/AIDS and gender staff visible and accessible to members of the disaster-affected population also provides an opportunity for vulnerable people to voice any concerns and access information and assistance. Care should be taken to provide several points of contact so that people requiring assistance or staff members are not stigmatised.



### *Co-ordination*

- Co-ordination between agencies and government where possible is important if humanitarian actors are to be held accountable in mainstreaming processes.
- Co-ordination between agencies can enable joint advocacy work in linking national HIV/AIDS policies to local disaster co-ordination mechanisms.
- Joint advocacy can be effective when monitoring enforcement of codes of conduct especially relating to sexual exploitation among humanitarian actors.
- Equitable co-ordination processes are important in linking with development actors and HIV-related authorities in planning who may otherwise become marginalised in emergency contexts.

**Useful Resources:**

- For a discussion on contesting gender approaches in humanitarian responses, see Bryne & Baden, *Gender, Emergencies and Humanitarian Assistance*, Report No 33, Bridge, IDS, 1995, www.bridge.ids.ac.uk/reports/re33c.pdf and Tallis, Vicci, *Gender and HIV/AIDS: An Overview Repor*t, Bridge IDS, 2002
- For useful gender mainstreaming guidelines in conflict situations see, www.genderandpeacekeeping,org
- IASC, *Code of Conduct: Sexual Exploitation and Abuse in Humanitarian Crise*s, 2002, http://www.humanitarianinfo.org/iasc/publications.asp

# CHAPTER THREE

# Mainstreaming HIV/AIDS in Organisations

## Key Issues

- Mainstreaming HIV/AIDS in organisations should involve supporting staff to minimise their vulnerability to HIV infection and to cope better with the effects of HIV/AIDS in their lives. This can be done through training staff on HIV/AIDS prevention and support to staff on sexual health especially through the development of workplace policies.
- Mainstreaming HIV/AIDS in organisations means that the organisation itself must modify the way it functions. This means reviewing fundamental approaches to humanitarian work by examining the root causes of crises, becoming more community-led and placing analysis of power relations at the centre of research and action. Organisational commitment to mainstreaming should be demonstrated through recruitment processes, inclusivity of HIV positive people, accountability of staff on issues of abuse of power through enforcement of codes of conduct, investing financially in mainstreaming and continuously discussing and documenting lessons with others.



***Supporting staff to minimise their susceptibility to HIV infection and to cope better with the effects of HIV and AIDS. This can include:***

- Developing staff understanding of HIV/AIDS and supporting staff to 'face up to' the issue. This can be done through first assessing the knowledge and attitude of staff and through providing interactive HIV/AIDS education that is designed based on staff learning needs. Involving HIV positive trainers can facilitate greater openness from staff.
- Involve all levels of staff in training where possible and appropriate.
- A training programme should be developed for short term staff (including short term contracts like truck drivers etc.) and volunteers on HIV/AIDS and gender awareness.
- Minimising staff susceptibility to HIV infection through recognising that the traumatising environment of emergencies can result in staff having unsafe sex as a coping mechanism. Sexual health needs of workers should be taken into account in training and staff support.
- Measuring the impact of staff training on mainstreaming could (in large organisations) be monitored through tracking staff practices concerning condoms, counselling, alcohol use, sexual relationships with community members etc., through an annual anonymous questionnaire. Numbers of days absence could be recorded by category such as sickness, sickness of dependent, compassionate leave, funeral or holiday. In small organisations, to protect confidentiality, financial impacts could be tracked instead of highlighting staff behaviour. This is difficult to track with short term humanitarian staff. However tracking can be relevant to long term humanitarian and development staff and by comparing staff patterns between different humanitarian responses over time.
- Learning about how HIV/AIDS is currently impacting on the organisation and predicting the impacts of HIV/AIDS on the organisation and planning potential responses. Creating a workplace policy on chronic and terminal illnesses including HIV/AIDS. Workplace policy should be developed in close consultation with staff after training has taken place.
- Guidelines regarding provision of post exposure prophylaxis (PEP) should be developed and implemented in programme context situations.

***Modifying the way the organisation functions in a time of HIV/AIDS. This can include:***

- Looking beyond technical approaches to emergencies toward addressing underlying causes highlighted by HIV/AIDS. Develop policy positions on issues highlighted in emergencies that are supported by long term advocacy campaigns.
- Renewing emphasis on participatory rather than top-down, donor-driven responses, with emphasis on community-led approaches that place analysis of power (within communities, between affected communities and relief organisations and others etc.) at the centre of analysis and action.
- Ensuring that mainstreaming is adopted from the beginning - at disaster preparedness stage and risk assessment stage during an emergency response.
- Ensuring recruitment processes include questions about attitudes to HIV, gender, ageism, disability and sexual violence when hiring people to work in an emergency situation.
- Preventing discrimination against HIV positive staff. Programme focused training should emphasise issues of non-discrimination against people living with or affected by HIV/AIDS and highlight the dangers of inappropriately identifying people living with, or potentially living with, HIV/AIDS.
- Staff codes of conduct relating to abuse of power should be incorporated into job descriptions. Staff should receive training on codes of conduct relating to potential abuse of power such as sexual exploitation.
- Recruiting HIV/AIDS and gender specific mainstreaming staff for programme implementation can assist in implementing the mainstreaming agenda. Where agencies do not have funds for this, selected staff or volunteers can act as HIV/AIDS and gender 'focal point staff'. Be careful that HIV/AIDS and gender focused workers do not become marginalised or inadvertently undermine an integrated approach where they end up bearing sole responsibility for mainstreaming. Ensure that HIV/AIDS and gender specific staff do not themselves become targets of stigmatisation.
- Ensuring financial decisions relating to workplace policy and programming are linked to the mainstreaming process. Funding proposals should include budget lines for mainstreaming HIV/AIDS such as training of staff; funding for HIV/AIDS expertise in carrying out assessments; HIV prevention education during programme activities etc.
- Including periodic reflection and reviews with staff on the mainstreaming process in work plans. Documenting mainstreaming experiences, sharing learning and expanding on and adapting existing guidelines.



**Useful Resources:**

- Sample training workshop formats on mainstreaming HIV/AIDS in development and humanitarian programmes are available in: Holden, Sue, *AIDS on the Agenda: Adapting Development and Humanitarian Programmes to meet the Challenge of HIV/AIDS,* p 316-321 and p 332 - 337, http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm
- For ideas on formulating a workplace policy see, Holden, Sue, *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes*, ActionAid, Oxfam GB, Save the Children, 2004, Chapter 7.
- For guidelines on provision of PEP, see IASC, *Guidelines for HIV/AIDS Interventions in Emergency Settings,* 2003, p. 98-100, http://www.humanitarianinfo.org/iasc/publications.asp
- CAFOD, *The Silent Emergency: HIV/AIDS in Conflicts and Disasters* (leaflet)

# CHAPTER FOUR

# Mainstreaming HIV/AIDS in Programmes: Emergency Preparedness[3] Phase

## Key Issues

- Disaster preparedness plans should carry out a situation analysis of how HIV/AIDS impacts on the programme context, in particular regarding current coping mechanisms and its impact on vulnerable groups. Community involvement in research is an important aspect of emergency preparedness planning and a good way of involving HIV positive people in planning emergency preparedness strategies.
- Advocating for HIV/AIDS mainstreaming among agencies, in government and among other humanitarian actors such as the military should be part of emergency preparedness activity.
- Promote HIV/AIDS Awareness and Prevention Programmes supported by Voluntary Counselling and Testing (VCT) referral.



### *Mainstreaming HIV/AIDS in emergency preparedness planning*

Disaster preparedness planning should include an analysis of how HIV/AIDS impacts on the programme area. This basic information will assist rapid assessments that are carried out at emergency response stage. Analysis should focus on areas including:

- HIV/AIDS prevalence levels in programme areas, broken down as much as possible by gender, region, urban/rural, age dimensions etc.
- Vulnerable groups and the risk factors that are increasing susceptibility to HIV infection.
- Methods being employed to cope with the impacts of HIV/AIDS.

Adopting community research approaches can help to respond to these questions and can be an effective way of ensuring people living with or affected by HIV/AIDS are at the centre of analysis and the planning of suitable emergency preparedness activities. Forming a 'stake holder's research advisory group' can create an effective space for people affected by HIV/AIDS to lead the planning process. Involving partner organisations, other local expertise in HIV/AIDS work and women's organisations is also important. This also strengthens monitoring systems at emergency response stage.

[3] Emergency preparedness is defined here as a process that aims to address the causes of an emergency in order to avoid its recurrence or mitigate its impact. It aims to strengthen resilience, especially of the most vulnerable households and communities, in particular, in coping with the consequences of emergencies. Emergency preparedness strategies involve developing the capacity of communities to address crisis more effectively and as part of a long term development strategy.

### *Advocacy Initiatives*

- Establishing an information sharing network which promotes mainstreaming HIV/AIDS that is available to key decision-makers at preparedness stage can enhance co-ordination efforts.
- Identifying gaps in national preparedness policies and plans can assist in advocating to ensure governmental emergency preparedness planning focuses on the most vulnerable members of the population.
- Where possible promote training programmes for uniformed forces such as military personnel on HIV/AIDS and codes of conduct regarding sexual exploitation.

### *Promote HIV/AIDS Awareness and Prevention Programmes supported by Voluntary Counselling and Testing (VCT) referral*

- Building HIV awareness through the development of HIV/AIDS prevention programmes is an important emergency preparedness activity. The continuation of HIV/AIDS awareness and prevention activity should be supported during an emergency situation.
- Awareness and prevention programmes should be supported by VCT referral facilities.



**Useful Resources:**

- For regional and country specific HIV/AIDS profiles see, www.UNAIDS.org and www.globalfund.org
- For a checklist of key aspects for consideration in compiling an emergency contingency plan see IASC, I*nter Agency Contingency Planning Guidelines For Humanitarian Assistance,* 2001, Link to I*ASC Guidelines for HIV/AIDS interventions in Emergency Settings,* 2003 p11, http://www.humanitarianinfo.org/iasc/publications.asp
- For guidance on community research skills in mainstreaming HIV/AIDS see, Holden, Sue, *AIDS on the Agenda, Unit 10, Undertaking Community Research for Mainstreaming AIDS in Humanitarian Work,* p 338 - 341, http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm
- For guidelines on appraising how research initiatives with HIV positive women meet participatory criteria see, The International Community of Women Living with HIV/AIDS, *Guidelines for Ethical Participatory Research with HIV Positive Women,* May 2004, http://www.icw.org/tikiread_article.php?articleId=29&highlight=guidelines%20for%20ethical%20participatory%20research%20with%20HIV%20positive%20women
- For up to date publications on evolving approaches to VCT, see http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Counselling_voluntary+counselling+and+testing.asp

# CHAPTER FIVE

# Mainstreaming HIV/AIDS in Programmes: Emergency Response Phase

*This section focuses on the early phase of an emergency and introduces ideas for minimum multi-sectoral responses to mainstreaming HIV/AIDS. Sectors covered here include:*

- *Risk Assessment, Monitoring, Evaluation and Impact Indicators*
- *Food Security, Nutrition and Food Aid*
- *Health*
- *Shelter, Settlement and Non-Food Items (NFIs)*
- *Water, Sanitation and Hygiene Promotion*



Recommendations cross-cutting to all sectors that follow are:

- Ensuring that HIV/AIDS awareness and prevention programmes are supported including provision of access to condoms in programme areas and the provision of VCT referral where possible.
- Mainstreaming HIV/AIDS approaches should emphasise ensuring that the interests and voices of vulnerable people are central to planning and programme implementation and that vulnerable groups benefit from humanitarian services. Vulnerability should remain a central criteria for programme inclusion rather than knowing people's HIV status as the majority of HIV positive people are unaware of their HIV status or fear their status being revealed due to the potential of social stigma.

## Section 1: **Risk Assessment, Monitoring, Evaluation and Impact Indicators**

### Key Issues

- Risk assessments should include HIV/AIDS specific questions that identify levels of susceptibility to HIV infection among different groups and the impacts of HIV/AIDS on the lives of the disaster affected population. Assessments should explore how an emergency response might minimise these risks and impacts.
- Information collection as part of assessments should be as far as possible community-based, conscious of vulnerable groups and adopt gender analyses.
- Good practice in monitoring and evaluation should be realistic in a humanitarian context (probably process based) and build on existing systems of data collection and analysis.

### *Risk Assessment*

Basing assessments on the concept of risk - to life, health, subsistence and physical security, meaning the product of imminent threats and vulnerabilities - can provide a strong basis for vulnerability analysis and analysis of people's ability to cope with disaster. All relevant stakeholders should be included in the assessment process. HIV/AIDS specific questions should be included in risk assessments such as:

- What are the current factors locally that will increase people's susceptibility to HIV infection? (e.g., deterioration of economic circumstances, disruption of HIV/AIDS prevention activity etc.). How might the emergency response minimise these risks and ensure that the response itself does not contribute to exacerbating these risks?
- How will the current circumstances increase the negative impact of HIV and AIDS on those already infected and affected by the disease? How might the emergency response minimise this negative impact and ensure that it does not cause increased difficulty to people infected and affected by HIV and AIDS?
- How might the current and future impact of HIV/AIDS affect communities' capacity to recover from the disaster? (i.e.: labour and skills constraints, prolonged dependency on external aid etc.). What long term plans might be put in place in order to assist the recovery of infected and affected people and build greater resilience within communities living with HIV/AIDS to cope with disasters?



### *Information Collection*

Useful tools for collection of information and analysis in identifying the impacts of HIV/AIDS on the community affected by crisis and existing power relations and patterns of behaviour that can lead to HIV infection can include: focused interviews through community-based research, group mapping exercises and 'site inventories'. Gender analysis is an essential aspect of this to identify the different needs of women and men, different constraints and abilities to participate in tacking their susceptibility to HIV infection and minimising the impacts of HIV/AIDS in their lives.

### *Monitoring, Evaluation and Impact Indicators*

Monitoring and evaluation of mainstreaming HIV/AIDS is difficult and will continue to be until agencies begin to more fully document positive effects from experience in terms of process, outcomes and impact of mainstreaming HIV/AIDS initiatives.

Impact indicators should demonstrate effectiveness in mainstreaming gender and HIV/AIDS by showing whether, and in what way, agencies have modified their core practices in light of HIV/AIDS and secondly by showing whether these changes to core practice are having a positive or negative effect on HIV susceptibility levels and the impact of HIV/AIDS on people's quality of life. Measuring the initial aspect of whether staff and programmes have been adjusted can be tracked internally. The second aspect of measuring the impact of such modifications is far more difficult in a humanitarian situation as detailed risk assessment and surveillance information may not be available. Expectations around monitoring and evaluation should be feasible. It is very difficult to measure whether HIV transmission has been minimised in a period of less than one year and in a crisis situation. IASC (2003) recommends short term process indicators such as monitoring distribution of condoms and mid-term indictors such as monitoring of incidence of STIs over time by building on existing systems of data collection and analysis (See IASC (2003) p. 30-1). Methods of monitoring should build on existing systems as part of ordinary systems of data collection and analysis.

**Useful Resources:**

- A useful briefing on mainstreaming HIV/AIDS in assessments: Smith & Maher*, Addressing the Silent Emergency: HIV and AIDS and the Darfur Crisis*, in, *NGO VOICE: Voice Out Loud*, Issue 1: October 2004, p 6-7
- Darcy, Griekspoor, Watson, *The Southern Africa Crisis, A Critical Review of Needs Assessment Practice and its Influence on Resource Allocation, Background Research for HPG Report 15*, September 2003, http://www.odi.org.uk/hpg/publications_reports.html.
- For guidance generally on assessments, Darcy, James, *Briefing: Humanitarian Needs Assessment and Decision-Making*, Sept. 2003, HPG; For the longer version see, Darcy & Hofmann, *According to Need? Needs Assessment and Decision-Making in the Humanitarian Sector,* 2003, HPG Report 15, http://www.odi.org.uk/hpg/publications_reports.html
- For a guide on mapping, site inventories, ethnographic guides and carrying out focus group discussions on HIV/AIDS see, Family Health International (FHI), *HIV/AIDS Rapid Assessment Guide*, 2001.
- For guidance in community based research see, Holden, Sue, *AIDS on the Agenda, Unit 10, Undertaking Community Research for Mainstreaming AIDS in humanitarian Work,* p 338 - 341.
- For a checklist of questions in carrying out a situation analysis and interviews on risky behaviour patterns see, IRC, *Protecting the Future: HIV Prevention, Care, and Support Among Displaced and War-Affected Populations,* 2003, Appendix A, pg 193 - 197, www.globalhealth.org/sources/view.php3?id=670.
- For resources on various gender analysis frameworks see, Bridge www.ids.ac.uk/bridge/index.html; Genie, www.genie.ids.ac.uk; Siyanda, www.siyanda.org
- For discussion on the challenge of monitoring and evaluating HIV/AIDS mainstreaming see, Holden, Sue, *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes*, Oxfam, ActionAid, Save the Children, 2004
- For guidance with process based indicators on mainstreaming HIV/AIDS see, IASC *Guidelines for HIV/AIDS Interventions in Emergency Settings,* 2003, p 30-1, http://www.humanitarianinfo.org/iasc/publications.asp
- USAID, *Handbook of indicators for HIV/STI programmes,* 2000, http://www.usaid.gov/our_work/global_health/aids/TechAreas/monitoreval/.

# Section 2: **Food Security, Nutrition and Food Aid**

## Key Issues

- Stress community-based approaches in targeting food aid by emphasising the participation of vulnerable groups and use an approach that avoids stigmatising people in the targeting process.
- Assess the size and composition of food rations in light of guidelines for PLWHA.
- Design food aid programmes to minimise potential for HIV transmission by prioritising the protection of vulnerable groups against sexual violence or coercion by community members or humanitarian actors.
- Create a supportive environment for PLWHA and vulnerable groups within the design of the food relief programme by including vulnerable groups in its design and developing mechanisms that prevent discrimination.
- Promote appropriate nutritional care for PLWHA through supporting existing institutions that work with PLWHA and by providing training on nutritional guidelines for PLWHA.



### *Targeting of Food Aid*

Targeting of food aid is a sensitive issue vis-à-vis HIV/AIDS as there are serious dangers of stigmatising people living with or affected by HIV/AIDS if targeting of relief food is not carried out in a sensitive manner. The recommended approach tends to be:

- Flexible and community-based targeting planned on a context specific basis. Agree criteria through consultation with stakeholders, including community groups.
- Targeting of individuals on the basis of food insecurity criteria and broader vulnerability criteria such as chronic illness rather than focusing on HIV status.
- Focus on vulnerable groups should include groups such as food insecure female, child and elderly headed households; households hosting orphans; food insecure households caring for chronically ill persons; individuals who identify themselves as affected by HIV/AIDS such as through existing home based care groups.
- Consulting with carers of people living with HIV/AIDS to identify any special support they may require due to factors such as having less time to access food relief or having fewer assets due to the costs of health care provision.
- Additional targeting of institutions such as orphanages, schools, hospitals, churches, MCH clinics and HBC programmes.

### *Food ration sizes and composition in light of HIV/AIDS*

It is important to assess food rations in terms of size and composition in light of HIV/AIDS as people living with HIV or AIDS may face greater risk of malnutrition.

- Include food items in the food package that meet recommended energy, protein, fat and micro-nutrient requirements of PLWHA.
- Consider including micro-nutrient fortified blended food and/or cereals in the food package. Consider including milled foods as they are less labour intensive for carers of PLWHA.
- Consider the needs of people with HIV/AIDS in composing the food package, such as inclusion of foods that may be easier to eat during periods of illness.

### *Designing food aid programmes that minimise potential for transmission of HIV infection*

- Consider holding food distributions at increased numbers and types of sites to shorten the walking distance and waiting time.
- Distribute food at a time of day most suitable for women to return home safely.
- Food aid programmes are in danger of creating increased levels of sexual violence and coercion by men involved in relief distributions. Training on codes of conduct on gender based violence and exploitation should be carried out and accountability enforced continuously throughout the relief programme.
- Assess whether the staff of the programme might increase rates of susceptibility to HIV infection. For example, does the programme employ truck drivers to travel long distances to deliver food? Does the programme employ workers who have migrated from their homes? If yes, establish HIV prevention education activities on behaviour change and ensure workers have access to condoms.
- Employ female staff at all levels of the programme in addition to identifying designated HIV/AIDS and gender focal point staff. If opting to identify focal point HIV/AIDS and gender staff, be cautious that their work is fully integrated into the organisational agenda and that they do not become marginalised bearing sole responsibility for mainstreaming HIV/AIDS or stigmatised in their role.
- Develop a communications plan around HIV/AIDS. Carry out HIV/AIDS sensitisation and prevention activities at distribution sites.



### *Creating a supportive environment for PLWHA and vulnerable groups within the design of the food relief programme*

- Include people with HIV/AIDS and vulnerable people in decision-making on issues of targeting and distribution planning. Orphans and vulnerable children and children in child-headed households can easily be left out and exploited in food relief programmes. Information should be simple and clear to enable children in charge of households to participate in planning.
- Consider establishing mobile food distributions; arranging home deliveries of food; arranging for collection of food by relatives of the sick; or developing village level storage plans.
- Consider designing smaller packages of food rations to facilitate their transport by physically weak people.
- Consider intra-household gender relations in designing the distribution process to prevent the erosion of women's positions in their households and community. In some, but not all cases, distributing food through women may be the most appropriate approach. Care should however be taken not to use women as conduits for food delivery which can create pressures on women and new forms of vulnerabilities. Include women as a central stakeholder group in the process of distribution plan design.
- Develop mechanisms that prevent discrimination against PLWHA or other vulnerable groups such as child-headed households who can easily be excluded. Enforce sanctions against humanitarian staff who discriminate against PLWHA or other vulnerable groups who meet programme entry criteria.
- Co-ordinate with home based care programmes as referral agencies for PLWHA who do not meet entry criteria to relief programmes as they may still require additional nutritional support.
- Take steps to minimise stigmatisation of PLWHA. Also minimise any potential exclusion from the programme of food insecure non-HIV/AIDS affected households.
- In the case of severely malnourished individuals, consider adopting the "community-based therapeutic care" (CTC) approach as an alternative to traditional therapeutic feeding approaches. CTC is an approach to therapeutic care that allows for treatment at home.

### *Promoting appropriate nutritional care for PLWHA*

- Identify existing community institutions that work with PLWHA (health centres, schools), groups (home based care groups, NGOs) and individuals (social workers). Carry out a rapid assessment of existing care systems for chronically sick patients, the effects of the crisis on these systems, current coping strategies, training needs and information gaps.
- Adapt nutritional care guidelines to local needs and possibilities. Train relevant local staff to inform and assist care givers and community workers on special eating needs of PLWHA, taking care of PLWHA and herbal treatments and remedies.
- Incorporate nutritional care for PLWHA into programmes of local institutions.

**Useful Resources:**

- O'Donnell, Michael, *Food Security, Livelihoods and HIV/AIDS: A Guide to the Linkages, Measurement and Programme Implications*, Save the Children p 12 - 15 and p 26-27, http://www.sarpn.org.za/documents/d0000898/index.php.
- Kadiyala & Gillespie, *Rethinking Food Aid to Fight AIDS,* International Food Policy Research Institute, October 2003, http://www.ifpri.org/themes/hiv/hivpubs.asp
- WHO, *Nutrient requirements for People Living with HIV/AIDS*, May 2003, www.who.int/nut/documents/hivaids_nut_require.pdf
- WFP, *Programming in the Era of AIDS: WFP's response to HIV/AIDS,* p 11, http://www.eldis.org/static/DOC11651.htm
- Collins, Steve, *Community Based Therapeutic Care, A New Approach for Selective Feeding in Nutritional Crises,* ODI, HPN, Network Paper, No. 48, November 2004, http://www.odihpn.org/publistResults.asp
- ACORD, *Unravelling the Dynamics of HIV/AIDS related stigma and discrimination: The Role of Community-Based Research*, June 2004, HASAP Publications. WHO, *Nutrient requirements for People Living with HIV/AIDS*, May 2003, http://www.acord.org.uk.
- FAO, *Living Well with HIV/AIDS: A Manual on Nutritional Care and Support for People Living with HIV/AIDS,* 2002, http://www.fao.org/documents/show_cdr.asp?url_file=/DOCREP/005/Y4168E/y4168e06.htm

# Section Three: **Health**

## Key Issues

- Ensure access to basic health care for the most vulnerable.
- Establish safe blood supply.
- Provide condoms and establish a consistent, adequate supply of good quality condoms.
- Establish Syndromic STI Treatment with social support for patients and partners.
- Establish injection drug user (IDU) appropriate care including drug dependence treatment, risk reduction information; access to sterile needles and syringes; condom provision; STI treatment.
- Provide confidential support to survivors of sexual violence through medical examination and treatment, counselling support and collection of forensic evidence if requested.
- Support the establishment of VCT services.
- Ensure safe baby deliveries as per minimum guidelines (IASC 2003).
- Undertake universal precautions in order to minimise potential for transmission of HIV from patient to patient, from health worker to patient and from patient to health worker.
- Ensure Post Exposure Prophylaxis (PEP) guidelines are developed and PEP treatment made available to humanitarian staff accordingly.
- Support access to Anti-retroviral therapy (ARV) treatment and mother-to-child transmission (MTCT) prevention support.
- Establishment of psycho-social support should be a central consideration of an emergency health programme.



### *Ensuring access to basic health care for the most vulnerable*

- Carry out a rapid assessment of health care capacity, accessibility and utilisation; carry out an analysis of existing public health risks; train staff to identify vulnerable groups; establish health services at community level (clinics, health posts); support level (health centres); provide referral service (hospitals); integrate services as much as possible within local health structures.

### *Ensuring a Safe Blood Supply*

- Appoint an emergency co-ordinator; develop clear policies and guidelines for the recruitment and care of donors, testing of blood, disposal of waste products.
- For essential items for collection, testing and transfusion of 1000 units of blood, see IASC (2003) p 66.

### *Provision of Condoms and Establishing Condom Supplies*

- Collaborate with existing AIDS groups in planning; provide an adequate, good standard supply of condoms; distribute condoms with culturally appropriate instructions in an appropriate way in consultation with the community; deliver condoms at the same time as other emergency supplies; ensure that how to reach vulnerable groups with condom supplies has been considered; provide condoms to populations beyond the emergency affected population; intermediary suppliers can be used such as IPPF, UNFPA, WHO, if the procurement process is difficult; provide female condoms where demand may be present.
- To calculate 3 months supply of male and female condom supplies and to access safe sex leaflets, see IASC (2003) p 69-70.

### *Establishing Syndromic STI Treatment*

- Provide early case management and establish user friendly, confidential services; establish guidelines for case management using the national treatment protocol if possible; establish consistent availability of required drugs; provide counselling services to patients and their partners where possible; promote condom use; monitor STI indicators and plan comprehensive STI programmes; train health personnel on STI diagnosis, treatment and social support.
- For a checklist of essential treatment items. See IASC (2003) p 74.



### *Ensuring IDU Appropriate Care*

- Carry out a rapid and informal assessment. See useful "Key Resources" in IASC (2003) p 78-9.
- Provide risk reduction information and peer education; ensure access to sterile needles and syringes; provide drug dependence treatment; carry out careful assessment on populations involved in drug using, types of drugs used etc. and develop activity plans; provide access to HIV/AIDS care for injecting drug users; limit injectable forms of drug treatment; target injecting drug users with safer sex education, condom provision and treatment of STIs.

### *Providing support to survivors of sexual violence*

- Provide medical examination facilities if sought by rape survivors; provide compassionate and confidential treatment and counselling; collect minimum forensic evidence for release to authorities if sought by the survivors of sexual violence.
- See checklist for treatment supplies and "Key Resources" in IASC (2003) for clinical management of survivors of sexual violence.

### *Support the establishment of VCT services*

- Availability of VCT services and referral is an important aspect of any emergency health programme in order to assist people in knowing their status and availing of counselling support. For further guidelines see 'VCT topics' at http://www.unaids.org.

### *Ensuring safe deliveries*

- Provide clean delivery kits for use by mothers or birth attendants; establish a support procedure for women with at-risk pregnancies; provide midwife delivery kits; establish essential obstetric care for complicated births; establish a referral system to manage obstetric emergencies; establish comprehensive services for antenatal, delivery and postpartum care.
- See "Key Resources" IASC (2003) for checklist for safe motherhood services p 83-84.



### *Universal precautions*

- Apply universal precautions to minimise the transmission of HIV from patient to patient, from health worker to patient and from patient to health worker.
- See IASC (2003) p 86-88 for an outline of universal precautions.

### *Ensuring Post Exposure Prophylaxis (PEP) is available to humanitarian staff*

- Post exposure prophylaxis is a short-term anti-retroviral treatment that reduces likelihood of HIV infection after potential exposure. Support should be provided to humanitarian staff to:
- Prevent exposure; if potential exposure to HIV occurs that it is managed appropriately; provision of PEP treatment where necessary based on clear guidelines. See IASC (2003) guidelines p 98-99

### *Access to Anti-retroviral (ARV) Therapy and Prevention of Mother-to-Child Transmission (MTCT)*

- While costs of ARVs have decreased in recent times, their cost remains a major obstacle to economically vulnerable people. Facilitating access to ARVs also requires a health infrastructure that enables their delivery. Currently only a tiny minority of HIV positive people who require ARV therapy are receiving treatment. Humanitarian situations place even greater obstacles to access and delivery. Access to ARVs is a critical and long-term battle in the fight against HIV/AIDS. For further information on this evolving debate see http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Antiretroviral+therapy.asp. For the WHO guidelines on delivery of ARVs see, http://www.who.int/hiv/topics/arv/en/index.html#what
- Similarly, only a tiny minority of women have access to preventative measures to protect their babies from HIV infection. For further information on MTCT see http://www.unaids.org/Unaids/EN/In+focus/Topic+areas/Mother-to-child+transmission.asp. For WHO guidelines on MTCT see http://www.who.int/hiv/pub/mtct/en/



### *Psycho-social Support*

Populations who undergo extreme levels of stress, such as high death rates among a community or high or systematic levels of physical and sexual violence in times of conflict require psychological, social and economic support. Establishing mental health care programmes should involve:

- Identifying local beliefs about mental illness
- Strategic screening of population through working with community health workers; social services; camp officials; community leaders; family systems; traditional health care providers; school teachers.
- Defining of clear goals of the programme with a short and long range view (such as: helping people in the community understand their options; reinforcing normal coping mechanisms; offering support to those who cannot cope in the current situation; preventing milder mental problems from becoming long lasting mental health disorders etc.).
- Developing an appropriate approach (such as: developing community support mechanisms; reinforcing every day routines; linking vulnerable groups such as women, children or elderly to support services).

**Useful Resources:**

- Much of this section is based on IASC, *Guidelines for HIV/AIDS Interventions in Emergency Settings,* 2003 which provides practitioners with a step by step guide to mainstreaming HIV/AIDS in the health sector in emergency response situations.
- For guidelines on establishing psychological support in crisis situations see, Abdallah, S, Burham, G (eds) *Public Health Guide for Emergencies*, Johns Hopkins School of Hygiene and Public Health, Baltimore, MD; International Federation of Red Cross and Red Crescent Societies, 2000; American Red Cross: *Disaster Mental Health Services: An Overview - Instructor's Manual*, January 2002; WHO, *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors,* 2003, www.who.int/disasters/repo/8656.pdf
- Websites, http://www.unaids.org; http://www.who.int

# Section 4: **Shelter, Settlement and Non-Food Items (NFIs)**

## Key Issues

- Establish concrete mechanisms for protection of vulnerable people against abuse and sexual violence by setting up representative planning groups. Specific attention should be given to questions of sexual and gender based violence. Humanitarian staff and other actors involved in relief operations should be accountable to codes of conduct on sexual exploitation.
- Essential needs of vulnerable groups should be provided for from the beginning of the response through additional support mechanisms for PLWHA, chronically sick people and other vulnerable groups.
- Potential for sexual violence in the layout and design of sites should be minimised by ensuring that vulnerable groups play a key role in site planning; replicating physical community and gender norms and establishing safe spaces for vulnerable groups such as unaccompanied children.



### *Establishing concrete mechanisms for protection against abuse and sexual violence*

- At camp level, establish refugee committees and specifically women's refugee committees to work together on issues relating to vulnerable groups. Create mechanisms that also ensure that men and boys are protected.
- Train women's refugee committees on how to respond to cases of sexual and gender based violence.
- Develop a continuous monitoring and planning system regarding support to vulnerable groups from organisational level to camp level. 'Community watch' initiatives with functioning reporting systems that link to existing committees, especially to women's refugee committees, can be effective.
- Camp settings must provide additional protection for separated children. Efforts should be made to trace their families; to arrange for fostering; or to provide special protection and psychological support for them within a social group.
- Place vulnerable households close to essential facilities (e.g.- water points; health facilities, waste disposal areas).
- Training of humanitarian staff and others such as peacekeepers and military on codes of conduct regarding sexual exploitation in humanitarian crisis is essential in developing a culture of accountability around gender and HIV/AIDS among humanitarian actors. Whenever possible, ensure deployment of female soldiers and police officers to oversee security matters.
- Ensure immediate action is taken where sexual violations occur.
- Establish professional, confidential counselling and advice services for survivors of sexual violence. Ensure that there is more than one member of staff associated with sexual abuse, as this can lead to stigmatisation of survivors.
- It is essential that peacekeepers, military and humanitarian staff are provided with the facts about HIV transmission and have sufficient access to condoms.
- Employ more female staff than male staff in particular with regard to registration and distribution activities.
- Develop security plans for the camp that minimise external security threats, such as banditry attacks or opportunities for sexual violence. Perimeter fencing around camps can prove a simple but effective deterrent.
- Ensure women's committees are centrally involved in designing NFI distributions.
- Establish women's 'spaces' for discussion and future planning such as women-only 'social centres'. Link the centres to awareness-raising on protection rights so that women understand the sources of protection and redress that are open to them.

### *Providing for essential needs of PLWHA and vulnerable groups from the beginning of the response*

- Establish support mechanisms for those who are unable to carry out key tasks (building shelters, collecting water and fuel, etc.).
- Make additional clothing and blankets available to people living with HIV/AIDS and other vulnerable groups such as chronically sick people. Chronically sick people may also require additional mattresses or raised beds.
- Provide additional cleaning materials such as bathing and laundry soap to households with chronically sick members.
- Provide households with chronically sick members with the choice to use less labour intensive fuels or to use fuel efficient stoves.

### *Minimising potential for sexual violence in the layout and design of sites*

- Involve vulnerable groups, in particular women, in the design and implementation of site layout and management.
- Replicate community norms (locating villages together) and gender norms in site layout; decentralise facilities as much as possible. Provide single family shelters rather than communal areas as far as possible.
- Create a safe living area for vulnerable groups (esp. unaccompanied children, adolescents).
- Ensure entrances to, and pathways in the sites are safe by avoiding creation of isolated or screened areas. Water access, fuel collection and garbage disposal routes should be safe and within recommended distances from any shelter.
- Ensure safe areas for community facilities. Establish separate toilet blocks for women and men; establish individual family toilet blocks. Establish safe play areas for children.
- Special consultation with women is required on issues such as privacy in accommodation design and sourcing and means of fuel collection and/or collection of wild foods.
- Consult with women on how to plan overseeing of water collection at water points.



**Useful Resources:**

- UNHCR, *Respect Our Rights: Partnership for Equality: Report on the Dialogue with Refugee Women,* 2001, http://www.womenforwomen.org/rarwri.html
- Handrahan, Lori, *Final Mission Report on Gender and SGBV Issues,* UNHCR, See especially checklist on gender mainstreaming in camps, p 44.
- Holden, Sue, *Aids on the Agenda*, *Unit 9 Mainstreaming AIDS in Humanitarian Work,* Outline of suggested Gender and Protection Workshop for training of humanitarian staff, given by Oxfam GB p 336-7, http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm.
- IASC, *Code of Conduct: Sexual Exploitation and Abuse in Humanitarian Crise*s, 2002, http://www.humanitarianinfo.org/iasc/publications.asp.

# Section 5: **Water, Sanitation and Hygiene Promotion**

## Key Issues

- Ensure the design of programmes does not heighten the spread of HIV infection by identifying safe locations for water points; safe methods of supervising water points and training staff on codes of conduct regarding sexual exploitation.
- Address the water and sanitation needs of people living with HIV/AIDS and vulnerable groups by ensuring their views are heard in planning; by establishing easy access to services and meeting additional practical needs of PLWHA and their carers in a manner that does not stigmatise them.
- Actively dispel myths about HIV transmission through water sources.

### *Ensuring the design of the programme does not heighten susceptibility to the spread of HIV infection*



- Place water points in safe areas that minimise risk of sexual violence against girls and women.
- Install lighting at the water points where possible in order to improve security.
- Identify a safe method of supervising water points. Recruiting women supervisors can be an effective method. However, care must be taken that these women do not themselves become targets of exploitation.
- Consider whether the programme staffing heightens potential for transmission of HIV infection. Does the programme allow staff to wield a lot of economic or political power in communities that could be vulnerable to abuse? Does the programme involve staff staying nights away from their families? Staff must be fully trained on codes of conduct on sexual exploitation and codes of conduct enforced. Staff should also be supported in dealing with issues of sexual health.

***Addressing the water, sanitation and hygiene needs of people living with HIV/AIDS and their carers, chronically sick and other vulnerable groups***

- Establish representative community based water and sanitation decision-making processes where the views of vulnerable groups are heard directly or indirectly by representation.
- Establish easy access to safe and reliable water sources and basic sanitation items and sanitation facilities including an accessible latrine for chronically sick people.
- Develop support mechanisms, such as special water deliveries to families with chronically ill members who do not have easy access to adequate amounts of water or washing material to meet the additional requirements of bathing and the washing of bed linen. Ensure that singling out families to receive additional items does not stigmatise them.
- Provide hygiene education to carers of people living with HIV/AIDS and chronically sick people on how to wash and where to dispose of waste while caring for sick people.
- Consider building family latrines. In camp situations, women may require a greater number of latrines than men.
- Construct water points that do not have handles that are too high or too difficult for children, sick or elderly people to operate.
- Consider distribution of bed-pans to households with chronically sick members. Provision of potties for children may also lighten the work burden on carers of chronically sick family members.
- Provide water and sanitation facilities in health centres and education sites and provide hygiene education in emergency education programmes.
- Establish discussion groups through water management committees or hygiene committees in order to directly dispel existing myths about spread of HIV infection through water transmission.



**Useful Resources:**

- Van Wijk, Christine, *HIV/AIDS and Water Supply, Sanitation and Hygiene*, WELL Fact Sheet, December 2003, http://www.lboro.ac.uk/orgs/well/resources/fact-sheets/fact-sheets-pdf/hiv-aids.pdf

# CHAPTER SIX

# Mainstreaming HIV/AIDS in Programmes Linkages to Development

## Key Issues

The enormous impacts of HIV/AIDS have challenged our understandings of what constitutes 'normal time' outside of disaster situations. The Southern Africa crisis 2002/03 highlighted this question in a particularly pressing manner.[4] While discussion is still ongoing around the lessons learned from the response to this crisis, it is clear that the impacts of HIV/AIDS have challenged traditional understandings of the meaning of a humanitarian 'emergency'. This highlights many difficulties for both the humanitarian and development sectors, such as how, or indeed whether, humanitarian and development actors should co-ordinate their work more intensively in light of HIV/AIDS, and the opportunities and threats which this prospect presents to development and humanitarian paradigms.



The sectors included in this section are necessarily limited in number and brief and cannot begin to touch on the vast range of relevant issues on linking mainstreaming HIV/AIDS to development. Instead this section aims to provide a snapshot of some activities that humanitarian agencies are undertaking to link mainstreaming HIV/AIDS activities to longer-term initiatives. The message from the literature is that mainstreaming HIV/AIDS in humanitarian action may require a more holistic and long-term approach. Hence the longer-term aspect of humanitarian recovery and beyond is a necessary part of the mainstreaming HIV/AIDS debate. Humanitarian practitioners may be required in future to pay closer attention to the development literature on mainstreaming HIV/AIDS. This chapter includes brief sections on the following sectors:

- Food Security, Nutrition and Food Aid
- Health
- Education
- Water, Sanitation and Hygiene Promotion

[4] Paul Harvey's article, *HIV/AIDS and Humanitarian Action, HPG Research Report*, April 2004, provides a most useful overview of lessons and can be found at: http://www.odi.org.uk/hpg/publications_reports.html.

### *Supporting the food security needs of HIV/AIDS affected populations*

Identify potential interventions to strengthen food insecure households and households affected by HIV/AIDS. Agencies are currently learning how to devise strategies to enhance people's resilience to cope with HIV/AIDS. Interventions can include devising activities focusing on: labour-sharing / labour minimising strategies (e.g.- conservation farming which spreads labour more evenly throughout the year; establishing community gardens where labour is provided based on community participation and at least some of the benefits go to the poorest and most vulnerable members of the community); income generation; asset protection; knowledge sharing; and strengthening of community institutions.

### *Food/Cash/Credit For Work*



- Food/Cash/Credit for work programmes should be designed so that labour constrained households are not excluded from the programme. Activities may be incorporated as part of the programme design such as working on land belonging to labour constrained households; building rain catchment structures for vulnerable households or developing community gardens where vulnerable households benefit from some of the produce. Free food aid can also be continued for those unable to take part in food for work. Community based planning should be employed so that any potential for stigma and discrimination in identifying participants is prevented.
- Design work programmes that do not always involve heavy labour in order to avoid adding to the already heavy workload of women and carers of chronically sick people. Heavy work can have negative effects such as exclusion of these groups or have negative impacts on women's nutritional status for example. Ensure that heavier work (often carried out by men) does not pay more than lighter work, therefore discriminating against women, children, sick and elderly.
- If 'Cash/Credit For Work' is being employed, consider the potential gendered impacts. Cash and credit may be taken out of the control of women, even if distributed directly to women. Carry out research into the type of relief to be distributed and develop a targeting system with central involvement of women in its design.

### *Considering provision of long term food safety nets to people living with and affected by HIV/AIDS and vulnerable groups*

Divergent views exist within the humanitarian sector about whether food should be used as a long-term safety net in areas of high HIV/AIDS prevalence. The potential benefits and costs of provision of long term food aid to PLWHA should be carefully considered. Food aid should not be assumed to constitute an "automatic" method of support. Some agencies have adopted a measured approach by providing food alongside 'added value' activities such as school gardens, nutritional education and HIV/AIDS awareness programmes. C-Safe in Southern Africa suggest the following possible interventions: school feeding with take home rations for families caring for orphans and their families; food for training for livelihoods diversification; food for home based care services; food for TB patients; food for vocational training for street children and orphans; food for work and food for training; food for ill people and their families.

### *Agricultural Inputs Programmes*

- Design programme entry criteria in light of potential constraints that may be experienced by vulnerable groups. Consider the possible stigma associated with efforts to include vulnerable groups.
- Distribute tools that are light enough for children and elderly people to use.
- Identify appropriate seed packages. Consider using low input, low labour cropping systems such as provision of vegetable seed for home garden cultivation which provide a good nutritional supplement for PLWHA or function as an additional source of income; provision of less labour intensive crops. Record local seed information by compiling "seed system profiles" with farmers, introduce learning on local seed systems in schools. HIV/AIDS can contribute to knowledge loss on local seed systems. Seed programmes should not further undermine local seed and knowledge systems.
- Consider the option of establishing seed fairs that may be more appropriate by leaving the choice of seed up to individual farmers.
- Extension services should be tailored to assist the most vulnerable households access helpful technologies.



**Useful Resources:**

- Bonnard, Patricia, *HIV/AIDS Mitigation: Using What We Already Know,* Food and Nutrition Technical Assistance, October 2002, http://www.fantaproject.org/downloads/pdfs/tn5_hiv.pdf. See p 6 for checklist of ideas for inventions in these areas.
- Loevinsohn & Gillespie, *HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding, Discussion Paper No 157,* International Food Policy Research Institute, http://www.ifpri.org/themes/hiv/hivpubs.asp
- The Regional Network on HIV/AIDS, Rural Livelihoods and Food Security (RENEWAL) are carrying out activities such as forming sector wide networks for research and policy dialogue; reviewing national agricultural policies and programmes; and linking research with community led action on food security and livelihoods. See website: http://www.ifpri.org/renewal/index.htm.
- On seed knowledge systems and HIV/AIDS see, Waterhouse, Rachael et al, *The Impact of HIV/AIDS on Farmers' Knowledge of Seed: Case Study of Chokwe District, Gaza Province, Mozambique,* ICRISAT, January 2004, http://www.sarpn.org.za/documents/d0000973/index.php.

## Section 2: **Health**

Minimal research has been carried out on how the right of access to basic health care should be recognised and acted on in humanitarian crises and linked to planning longer-term health initiatives after the emergency response stage for the benefit of PLWHA and chronically sick. Some commentators have argued that humanitarian programmes should aim to support expanded health care even if restricted to a short-term emergency basis as this may act as a catalyst for improved healthcare access in the long term.

**Useful Resources:**

- Griekspoor, A, *Food Security, HIV/AIDS and the Health Care Gap in the 2002/3 Southern Africa Crisis,* forthcoming in *Disasters* Journal 2004
- For an insight into HIV positive women's experience of health care services in Zimbabwe see, Feldmen, Manchester & Maposhere, *Positive Women, Voices and Choices,* International Community of Women Living with HIV/AIDS, 2002, http://www.kubatana.net/html/archive/hivaid/020701wasn.asp?sector=HIVAID, Chapter 5
- Equinet is an organisation which advocates for more equitable health systems in Africa to support people living with HIV/AIDS, http://www.equinetafrica.org.



## Section 3: **Education**

### *Children's Access to Education*

During emergencies and in particular during complex emergencies, children's access to education should be ensured either by supporting existing schooling facilities or by creating schooling facilities. Schools should be developed as community institutions through the creation of linkages with humanitarian services. Schools should provide protection to children and teachers through clear codes of conduct and the provision of psycho-social support in crisis situations. Schools should be utilised as an opportunity for carrying out HIV/AIDS life skills education.

**Useful Resources:**

- Information on mainstreaming HIV/AIDS and gender in education in humanitarian situations see IASC, *Guidelines for HIV/AIDS Interventions in Emergencies,* 2003, Sector 8, p 90-1, http://www.humanitarianinfo.org/iasc/publications.asp
- Interagency Network for Education in Emergencies, *Handbook: Minimum Standards For Education in Emergencies,* 2004, http://ineesite.org/standards/msee.asp
- For training curricula on HIV/AIDS education UNICEF has compiled numerous manuals as part of their Life Skills Programme. See http://www.unicef.org/lifeskills/index_14926.html.

### *Developing a long term approach to water and sanitation policy in light of HIV/AIDS*

- Develop community-based strategies for identifying sites for water and sanitation inputs. For example, the Zimbabwe Red Cross links its projects closely with Home Based Care Programmes as a strategy for identifying where water and sanitation inputs are urgently required. This approach adds value to the entire community water supply and can reduce stigma associated with the HBC programme. Some agencies also promote the development of nutrition gardens managed by support groups using the run off from new or rehabilitated boreholes.
- Scale up research and use of designs for water systems requiring less robust, complex and expensive maintenance. Also develop research on and use of home based water systems, including home based treatment of drinking water which make communities less dependent on outside support. Innovations such as SODIS, or solar water disinfection, may be suitable for household use.



### *Ensuring households affected by HIV/AIDS can access water for productive agricultural purposes*

- Provide households affected by HIV/AIDS with access to water for productive agricultural purposes to improve income levels, food security and nutrition levels. This can be linked to water harvesting programmes, kitchen garden programmes, innovation around and advocacy for access to land and marketing.

**Useful Resources:**

- Van Wijk, Christine, *HIV/AIDS and Water Supply, Sanitation and Hygiene*, WELL Fact Sheet, December 2003, http://www.lboro.ac.uk/orgs/well/resources/fact-sheets/fact-sheets-pdf/hiv-aids.pdf
- Information on Solar Water Disinfection can be found at, http://www.sodis.ch/

# CONCLUSION

The literature on HIV/AIDS is currently evolving and is being added to and updated continuously. This resource has drawn extensively on the key texts that currently exist on mainstreaming HIV/AIDS in humanitarian action. The purpose of the resource is to prompt practitioners to begin utilising and negotiating between these key texts in their work. The current key texts that practitioners should familiarise themselves with include:

Theoretical and lesson learning texts:

- Harvey, Paul, *HIV/AIDS and Humanitarian Action,* HPG Research Report, April 2004, http://www.odi.org.uk/hpg/publications_reports.html
- Holden, Sue, *AIDS on the Agenda; Mainstreaming HIV/AIDS in Development and Humanitarian Programmes,* ActionAid, Oxfam GB, Save the Children UK, 2003, http://www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm
- Holden, Sue, *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes,* ActionAid, Oxfam GB, Save the Children UK, 2004 (A summarised version of *AIDS on the Agenda)*
- Smith, Ann, *HIV/AIDS and Emergencies: Analysis and recommendations for practice,* ODI Network HPN Paper, February 2002, www.odihpn.org/pdfbin/networkpaper038.pdf



Manuals / Guidelines:

- IASC, *Guidelines for HIV/AIDS Interventions in Emergency Settings,* 2003, http://www.humanitarianinfo.org/iasc/publications.asp.
- Oxfam Great Britain, *Integrating and Mainstreaming HIV/AIDS in Emergencies,* http://www.oxfam.org.uk/what_we_do/emergencies/how_we_work/manuals.htm.
- Health Economics and HIV/AIDS Research Division *(HEARD)* at the University of KwaZulu-Natal hosts a website with HIV/AIDS training resources and toolkits. See http://www.ukzn.ac.za/heard/Index.htm.

The recent tsunami disaster in Asia has further highlighted the urgency of mainstreaming HIV/AIDS in humanitarian action. Some rapid responses to the challenges of mainstreaming HIV/AIDS at the height of the disaster have been documented on the British Medical Journal website, see http://bmj.bmjjournals.com/cgi/eletters/330/7482/59#92036.

Lessons learned so far from mainstreaming HIV/AIDS in relation to humanitarian practice include recognition of the need for: more substantial organisational commitments to mainstreaming HIV/AIDS institutionally and in humanitarian programmes; challenging of damaging power relationships in organisations and between stakeholders in humanitarian programmes and the prioritisation of protection of vulnerable groups; and the consideration of longer range, more holistic analysis of the relationship between HIV/AIDS and humanitarian action.

Mainstreaming HIV/AIDS in humanitarian practice therefore demands concerted and long term efforts at personal, agency and interagency levels, within programme contexts and across diverse sectors. For the Irish humanitarian community, initial learning implications may include:

- Developing or strengthening of ongoing internal mainstreaming processes.
- Introducing processes within humanitarian programmes to test, adapt and build on some of the existing suggestions in guidelines for mainstreaming HIV/AIDS.
- Establishing and strengthening mechanisms for learning, documenting and sharing lessons in a collaborative way.

These relatively simple steps should contribute to building approaches to humanitarian action that are more self critical and responsive to the monumental human suffering that is a consequence of HIV/AIDS.

# Dóchas

The Irish Association of Non Governmental Development Organisations

***Dóchas is a network of Irish Non-Governmental Organisations (NGOs) involved in development and relief overseas and/or in the provision of development education.***

***Dóchas provides a forum for consultation and co-operation between its Members and helps them speak with a single voice on development issues. Dóchas is not a funding agency and is not involved in overseas projects.***



## Background

Dóchas was formed in October 1993, and is the result of a merger between CONGOOD – which represented the common interests of Irish Development NGOs since 1974, and the Irish National Assembly – which linked most Irish Non-Governmental Development Organisations (NGDOs) into a European Union NGO network.

Dóchas aims to add value to the Irish development sector, by providing its members with a forum to come together, share experiences and learning, and to deal with issues collectively. In this way, Dóchas contributes to enhancing the work of its members, but it also represents the views of Irish NGOs in relation to the Irish government, in particular the Department of Foreign Affairs and its development cooperation directorate, DCI.

## Membership

Membership of Dóchas is open to non-profit making NGDOs independently established and located in the Republic of Ireland or in Northern Ireland, who regard international development cooperation – including development education – as an important aspect of their aims and work. A full list of the rules and criteria for membership is available from the Dóchas office on request. A list of Member organisations is available from the Dóchas office or on our website.

## Governance

Dóchas is governed by its members, through the Annual General Meeting which elects an Executive Committee to manage the network on behalf of the members. The Executive Committee is assisted by a Secretariat which is responsible for the day-to-day business of the network.

Dóchas is funded by membership contributions and a multi-annual grant from Development Cooperation Ireland. Dóchas has also received occasional funding from other sources, such as the European Commission.

Dochas

The Irish Association of Non Governmental Development Organisations

**To comment on, or order copies of this resource, please contact:**

Dóchas
12 Harcourt St
Dublin 2
Ireland

**Tel:** + 353 1 4053801
**Fax:** + 353 1 4053802
**Email:** anna@dochas.ie
**Web:** www.dochas.ie